STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	04/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN47170

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F0000	This visit was for Investigation of Complaints IN00088379 and IN00088699. Complaint IN00088379 - Substantiated. Federal/state deficiencies related to the allegations are cited at F272, F279, F282, F312 and F328. Complaint IN00088699 - Substantiated. Federal/state deficiencies related to the allegations are cited at F272, F279 and F312. Unrelated deficiency cited. Survey dates: 4/4 and 4/5/11 Facility number: 000421 Provider number: 155417 AIM number: 100288340 Survey team: Jennie Bartelt, RN Census bed type:	F0000	**This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **Hickory Creek at Scottsburg desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on May 5, 2011.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 33 Total: 33 Census payor type: Medicare: 3 Medicaid: 25 Other: 5 Total: 33 Sample: 9 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 4/11/11 by Suzanne Williams, RN			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, interview, and record review, the facility failed to ensure a resident's skin was assessed completely and consistently related to a wound at the dialysis fistula site. The deficient practice affected 1 of 4 residents reviewed related to	F0272	**F272 It is the policy of this facility to conduct initial and periodic comprehensive, accurate, standardized, and reproducible assessment of the resident's functional capacity, including complete and consistent assessments of skin, including any identified wound at the dialysis fistula site and routine assessment**	05/05/2011

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	assessment of wounds in a sample of 9. The facility also failed to assess the resident's dialysis fistula site as indicated by patient education materials. The deficient practice affected 1 of 1 resident reviewed related to dialysis site care in a sample of 9 residents. (Resident F) Findings include: The clinical record for Resident F was reviewed on 4/4/11 at 4:15 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease. A. A physician's order was received on 3/21/11 and indicated, "Apply Bacitracin [antibiotic ointment] daily to blisters on LUE [left upper extremity]. Keep area covered and clean." Documentation on Nurse's Notes failed to indicate an assessment of the area of the upper arm requiring treatment.		**for infection and the thrill and bruit of the dialysis fistula site. 1.What corrective action will be accomplished for those residents found to have been affected by the deficiency? The wound that was at the dialysis fistula site on the right upper forearm of Resident F has healed. The Director of Nurse's will inservice all staff RNs and LPNs on dialysis fistula site care, including assessing the site every shift for signs/symptoms of infection and checking the dialysis fistula site for bruits and thrills. Dialysis fistula site assessments and bruit & thrill checks shall be done every shift and documented on the treatment administration record (TAR). If the nurse finds wound issues at the dialysis fistula site or an absence of bruit & thrills, the resident's attending physician and legal representative shall be notified of the change in condition. The nurse will also document the assessment results which indicate a change in condition in the resident's medical record and on the 24 hour report. 2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No other residents were**	

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	The Treatment Record for March 2011 indicated an entry for "Apply Bacitracin ointment to blisters on RUE [sic] [right upper extremity]. Keep area covered and clean." Documentation after the treatment was completed on 3/29/11, indicated, "Healed." During observation of Resident F's dialysis access site on 4/5/11 at 1:25 p.m., the MDS (Minimum Data Set) Coordinator was interviewed. She indicated the resident had a dialysis shunt to the upper right arm and attended dialysis three times a week on Monday, Wednesday, and Friday. The MDS Coordinator indicated the resident had what was thought to be a tape burn to the area where the dialysis dressing was placed after her dialysis treatment. The fistula site on the inside of the resident's upper right arm was observed to have pinhead-sized scabbed areas in a line at the dialysis needle insertion sites.		**affected by this practice. No other resident(s) residing at the facility receive dialysis services. 3.What measures will be put into place to ensure this practice does not recur? As stated above the wound that was at the dialysis fistula site on the right upper forearm of Resident F has healed. Dialysis fistula site assessments and bruit & thrill checks shall be done every shift and documented on the treatment administration record (TAR). If the nurse finds wound issues at the dialysis fistula site or an absence of bruit & thrills the resident's attending physician and legal representative shall be notified of the change in condition. The nurse will also document the change in condition and any new orders from the attending physician in the resident's medical record and on the 24 hour report. The DON or designee will review the 24 hour report and focus charting at least 5 days a week. If the DON identifies assessments not done per facility policy she will make sure that an assessment is done as soon as possible and interventions for the resident are updated and put into place. Once the assessment is complete, the DON will address the issue with the staff**	

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	During interview on 4/5/11 at 2:40 p.m., the Director of Nursing (DON) indicated she could find no assessment of the area on Resident F's arm in the clinical record or on the skin care sheets in the Skin Book binder maintained at the nurse's station. The DON indicated the resident always returned from dialysis with a pressure dressing to her shunt site, and the dressing was to be removed after eight hours. The DON indicated on 3/21/11 the dialysis center called the facility to let the facility know the resident's skin at the access site had a problem. The DON indicated the dialysis center would get very upset if the facility left the pressure dressing on the site. The DON indicated she remained at the facility until the dressing was to be removed on 3/21/11, so she would know what the problem was. She indicated when she looked at the site she first "thought it was ringworm," but when she looked closer, she realized there were tiny		**involved, including re-training as necessary and progressive disciplinary action for continued noncompliance. The DON or designee reviewing the 24 hour report and focus charting will complete the QA audit form F272 at least 5 days per week and bring the results to the daily interdisciplinary team meeting for review. 4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON will bring the results of the QA audits to the interdisciplinary team meeting 5 days per week, the weekly Standards of Care meeting, the monthly QA&A Committee meeting and to the quarterly QA&A Committee meeting that is attended by the medical director for review and recommendations. The QA audit-272 will be done 5 days a week for 30 days, then weekly for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be discontinued by the QA&A Committee when 100% compliance is achieved. This process and review of the 24-hour report and review of the focus charting 5 days per week will continue on an**	

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	blisters on the resident's skin at the access site. The DON indicated the dialysis center did not send written documentation to the facility about the skin problem. The DON indicated she could find no documentation of further assessment of the wound on 3/21/11, or that the wound was assessed again until the note on the Treatment Record indicating the wound was healed on 3/29/11. B. Resident F's care plan, originally dated 10/1/09, and most recently updated with a Goal and Target date of 5/2011, indicated a Problem/Need of "I go to dialysis 3 times a week. I have end stage renal disease." The only intervention related to the resident's dialysis access site indicated, "Check access site for S/S [signs and symptoms] of infection." A Hemodialysis Flow Sheet, dated 6/28/10, from the resident's previous dialysis provider indicated the resident had an AV		**ongoing basis even when documented audits are no longer required by the QA&A Committee. Date of compliance: May 5, 2011.** **Addendum to F 272** **a.)** ***What system is in place to ensure lack of skin assessment does not recur?*** **It is the policy of this facility that residents receive at least two (2) showers or tub baths per week, with partial baths between showers. Each time the resident has a shower or full bath, the CNA fills out a "Shower Day Skin Audit" (form HC-N-37). If a CNA discovers a skin issue of any kind, it is documented at that time on the audit form and reported to the charge nurse immediately.** **In addition to the above, the charge nurse performs weekly skin assessments on all residents and documents findings on the "Weekly Skin Assessment-HC-N-38" form (see attachments). These are placed with the focus charting for review by the DON each morning as part of her routine duties.**	

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	(arteriovenous) fistula to the upper right arm. During interview on 4/5/11 at 3:30 p.m., upon request for the facility's policy related to dialysis fistula care, the DON provided a policy entitled, "Shunt Care, Dialysis" and indicated the facility did not have a policy specific to care of a fistula access for dialysis. On 4/5/11 at 10:00 p.m., review of the website http://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-(av)-fistula-?-the-gold-standard-hemodialysis-access/e/1301 included, but was not limited to, the following related to assessment of the fistula site: "The vibration of blood going through your arm is called the 'thrill.' You should check this several times a day. If the 'thrill' changes or stops a blood clot may have formed. By immediately contacting your doctor or dialysis health care team the clot may be		**The Shower Day Skin Audit forms are given to the DON each day so that she may review each one. In addition, the DON will review the focused charting and 24 hour report each morning as part of her tour of duty. This allows her to follow up on any identified issues at that time to make sure that the necessary interventions have been put into place. In addition, if she does not receive a skin audit form on the day that a resident's shower/bath was scheduled or if a Weekly Skin Assessment has not been done or completed with accurate information, this will indicate the need for her follow up with the individual nurse or CNA. She will then intervene as indicated in question #3.** **b.)** ***Were other residents with other skin needs assessed?*** **All other residents' skin has been assessed since the survey and any identified**	

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	quickly dissolved or removed. Using a stethoscope, or even putting your ear to the access, you can hear the sound of blood flowing through your access. This sound is called the 'bruit.' If the sound gains in pitch and sounds like a whistle, your blood vessels could be tightening (called stenosis). If the tightening becomes too severe, blood flow could be cut off completely." During interview on 4/5/11 at 3:30 p.m., the MDS (Minimum Data Set) Coordinator indicated nothing on the record indicated the resident's dialysis fistula site was assessed routinely for signs and symptoms of infection or for the thrill and bruit. She indicated the site would be observed during care but not on a consistent routine basis. This federal tag relates to Complaint IN00088379 and IN00088699. 3.1-31(a)		**skin issues have been assessed, documented and treated.** **c.) *Has the re-training and/or in-service been completed?*** **Yes, inservicing was done on April 19, 2011.** **d.) *What was the content?*** **Inservicing content included, the facility policy and procedure for shunt care and fistula care, including assessing and monitoring the dialysis shunt/fistula site for signs/symptoms of infection from the Gold Standard Hemodialysis Access-DaVita.** **In addition to the above non-licensed nursing staff have been re-inserviced on the facility policy and procedure for completion of the shower day skin audits and licensed nursing staff have been re-inserviced on the policy and procedure for weekly skin assessments.** **All other residents' skin has been assessed since the**	

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			survey and any identified skin issues have been assessed, documented and treated.	
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review, and interview, the facility failed to ensure care was planned related to wound care for 1 of 4 residents reviewed related to wound care in a sample of 9. (Resident F) The facility also failed to ensure care was planned related to management of a dialysis fistula for 1 of 1 resident reviewed related to a dialysis fistula in a sample of 9. (Resident F)	F0279	**F279 It is the policy of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive care plan that includes measureable objectives and timetables to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, including interventions for wound care and management of a dialysis fistula. 1.What corrective action will be accomplished for**	05/05/2011

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	Findings include: The clinical record for Resident F was reviewed on 4/4/11 at 4:15 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease. A. A physician's order was received on 3/21/11 and indicated, "Apply Bacitracin [antibiotic ointment] daily to blisters on LUE [left upper extremity]. Keep area covered and clean." Documentation on the clinical record failed to indicate a plan related to the care of the area of the upper arm requiring treatment. The Treatment Record for March 2011 indicated an entry for "Apply Bacitracin ointment to blisters on RUE [sic] [right upper extremity]. Keep area covered and clean." Documentation after the treatment was completed on 3/29/11, indicated, "Healed."		**those residents found to have been affected by the deficiency? Resident F care plan has been updated to include specific dialysis fistula site care and checking the dialysis fistula site for bruit & thrills every shift. The wound that was at the dialysis fistula site on the right upper forearm of Resident F has healed. 2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No other residents were affected by this practice. No other resident(s) residing at the facility receive dialysis services. 3.What measures will be put into place to ensure this practice does not recur? The licensed nurses including the MDS Coordinator and Director of Nurses will be inserviced on completing accurate assessments, as well as the frequency, method and timeliness required to update care plans and interventions as the resident assessment is complete. Care plans shall continue to be initiated upon the admission/readmission of each resident to the facility, reviewed, and updated at intervals throughout the resident's length of stay. Once completed, the resident will be**	

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	During observation of Resident F's dialysis access site on 4/5/11 at 1:25 p.m., the MDS (Minimum Data Set) Coordinator was interviewed. She and indicated the resident had a dialysis shunt to the upper right arm and attended dialysis three times a week on Monday, Wednesday, and Friday. The MDS Coordinator indicated the resident had what the nurse thought was a tape burn to the area where the dialysis dressing was placed after her dialysis treatment. The MDS Coordinator indicated her understanding was the four corners of the taped area a dressing was covering had been visible on the resident's skin. The fistula site on the inside of the resident's upper right arm was observed to have pinhead-sized scabbed areas in a line at the dialysis needle insertion sites. During interview on 4/5/11 at 2:20 p.m., the Director of Nursing (DON) indicated she would expect		**re-evaluated for appropriate interventions. Care plans and CNA assignment sheets will be updated as needed to match the assessed status of the resident. At least 5 days a week, the DON will review the 24 hour report, focus charting, and any other associated documentation to identify any resident who has had a change in condition or functional capacity, including a wound or other skin issues. She will make sure that an assessment is done and followed through in the care plan and CNA assignment sheets, if indicated. Once the assessment and care plan is complete, the DON will address the issue with the staff involved, including re-training as necessary and progressive disciplinary action for continued noncompliance. The DON or designee reviewing the 24 hour report and focus charting will complete the QA audit form F279 at least 5 days per week and bring the results to the interdisciplinary team meting at the next scheduled morning management meeting that is held at least 5 days per week. In addition, any resident changes will be discussed weekly at the Standards of Care meeting. These processes and reviews will continue on an**	

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	to find a short term care plan related to the care of the wound that required the treatment with Bacitracin. During interview on 4/5/11 at 2:40 p.m., the Director of Nursing (DON) indicated she could find no care plan related to the area on Resident F's arm in the clinical record or in the binder for the current Nurse's Notes, maintained at the nurse's station. B. Resident F's care plan, originally dated 10/1/09, and most recently updated with a Goal and Target date of 5/2011, indicated a Problem/Need of "I go to dialysis 3 times a week. I have end stage renal disease." Approaches on the care plan indicated, "Check access site for S/S [signs and symptoms] of infection; Remind me of dialysis days; diet as ordered; Arrange for my transportation to and from dialysis; Send a blanket with me because sometimes I get cold; When it's cold out, put my coat on		**ongoing basis. 4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON will bring the results of the QA audits to the interdisciplinary team meeting 5 days per week, the weekly Standards of Care meeting, the monthly QA&A Committee meeting and to the quarterly QA&A Committee meeting that is attended by the medical director for review and recommendations. The QA audit-279 will be done 5 days a week for 30 days, then weekly for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be discontinued by the QA&A Committee when 100% compliance is achieved. This process and review of the 24-hour report and review of the focus charting 5 days per week will continue on an ongoing basis even when documented audits are no longer required by the QA&A Committee. Date of compliance: May 5, 2011.** **Addendum to F 279** ***Were other residents care plans reviewed?*** **Yes. All other residents identified as having skin issues or wounds have had their care plans reviewed**	

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	me because I get cold easy." Documentation failed to indicate other care was planned related to the access site. A Hemodialysis Flow Sheet, dated 6/28/10, from the resident's previous dialysis provider, indicated the resident had an AV (arteriovenous) fistula to the upper right arm. During interview on 4/5/11 at 3:30 p.m., upon request for the facility's policy related to dialysis fistula care, the DON provided a policy entitled, "Shunt Care, Dialysis" and indicated the facility did not have a policy specific to care of a fistula access for dialysis. On 4/5/11 at 10:00 p.m., review of the website http://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-(av)-fistula-?-the-gold-standard-hemodialysis-access/e/1301 included, but was not limited to, the following		**and updated as needed. The DON will check for completion of any newly identified skin issues as part of her review of the focus charting, 24 hour report, shower day skin audit sheets, and weekly skin assessment sheets.** **If she finds any issues, she will follow up as indicated in the plan of correction #3.**	

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	related to care of the fistula site: "Any restriction of blood flow can cause clotting. Here are some tips to help keep blood flowing without restriction: Avoid tight clothing or jewelry that could put pressure on your access area; do not carry bags, purses or any type of heavy item over your access area; don't let anyone put a blood pressure cuff on your access arm - have your blood pressure taken from your non-access arm.; request that blood being drawn is taken from your non-access arm; don't sleep with your access arm under your head or pillow; check the pulse in your access daily. The vibration of blood going through your arm is called the 'thrill.' You should check this several times a day. If the 'thrill' changes or stops a blood clot may have formed. By immediately contacting your doctor or dialysis health care team the clot may be quickly dissolved or removed. Using a stethoscope, or even putting your ear to the access, you can hear the sound of blood flowing			

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	through your access. This sound is called the 'bruit.' If the sound gains in pitch and sounds like a whistle, your blood vessels could be tightening (called stenosis). If the tightening becomes too severe, blood flow could be cut off completely." This federal tag relates to Complaint IN00088379 and IN00088699. 3.1-35(b)(1) 3.1-35(d)(2)(b)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure physician's orders were followed for dressing changes to a gastrostomy tube site for 1 of 4 residents reviewed related to physician's orders for wound care in a sample of 9 residents. (Resident B)	F0282	**F282 It is the policy of this facility that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care including administration of treatments as ordered by the physician. 1.What corrective action will be accomplished for those residents found to have been affected by the deficiency? The nurse(s) that worked the night of April 2nd and April 3rd have received**	05/05/2011

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	Findings include: During observation with the Director of Nursing (DON) on 4/4/11 at 4:55 p.m., Resident B's gastrostomy tube dressing was observed with the date of 4/1 followed by a nurse's initials. During interview at this time, the DON indicated the dressing was changed on 4/1/11 by (name of nurse). The DON indicated the dressing and gastrostomy stoma site were clean. Observation indicated the dressing was not soiled, and the site had slight crusting and slightly reddened skin surrounding. The clinical record for Resident B was reviewed on 4/4/11 at 1:00 p.m. Physician's orders for April 2011 indicated an order for "Cleanse G-tube [gastrostomy tube] site stoma [symbol for with] warm H2O [water] & soap, pat dry, & apply drain sponge."		**disciplinary action for failure to follow physician orders for a dressing change. The licensed nurses and QMA will be inserviced on following physician orders for medication & treatments including dressing changes to a gastrostomy tube site, the five (5) R's of medication administration, and the expectation that physician orders will be followed as given. 2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No other residents have been found to be affected. The Director of Nurses or designee will perform random dressing change checks 5 days per week for 30 days , then 3 times per week for 30 days to ensure dressings and treatments are done per physician orders. If any treatment or dressing is noted not done as ordered by the attending physician the treatment shall immediately be done as ordered and the attending physician and legal representative shall be notified. Once the resident's needs have been taken care of, the Director of Nurse's will address the identified issue(s) with the involved staff, including re-training as necessary and**	

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	The Treatment Record for 4/1, 4/2, 4/3, and 4/4/11 indicated the dressing had been changed as ordered on the 10:00 p.m. to 6:00 a.m. shift. Nurse's Notes for 4/1/11 at 12:00 a.m. and 4/2/11 at 1:00 a.m. indicated the stoma was cleansed as ordered. The note for 4/1/11 also indicated a drain sponge was applied. During interview on 4/5/11 at 2:20 p.m., the DON indicated she did not re-check the initials on the dressing dated 4/1/11. She indicated the nurses on the subsequent dates had told her the dressing was changed. She indicated she had no reason to think the dressing had not been changed by the nurse as indicated on the Treatment Record, and she wondered if the date of 4/1 on the dressing was just mis-dated. This federal tag relates to Complaint IN00088379.		**progressive disciplinary action for continued noncompliance. The DON or designee reviewing the 24 hour report and focus charting will complete the QA audit form F282 at least 5 days per week and bring the results to the interdisciplinary team meting at the next scheduled morning management meeting that is held at least 5 days per week. In addition, any resident changes will be discussed weekly at the Standards of Care meeting. These processes and reviews will continue on an ongoing basis. 3.What measures will be put into place to ensure this practice does not recur? As stated above the Director of Nurses or designee will perform random dressing change checks 5 days per week for 30 days , then 3 times per week for 30 days to ensure dressings and treatments are done per physician orders. If any treatment or dressing is noted not done as ordered by the attending physician the treatment shall immediately be done as ordered and the attending physician and legal representative shall be notified. Once the resident's needs have been taken care of, the Director of Nurse's will address the identified issue(s) with the involved staff, including**	

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	3.1-35(g)(2)		**re-training as necessary and progressive disciplinary action for continued noncompliance. The DON or designee reviewing the 24 hour report and focus charting will complete the QA audit form F282 at least 5 days per week and bring the results to the interdisciplinary team meting at the next scheduled morning management meeting that is held at least 5 days per week. In addition, any resident changes will be discussed weekly at the Standards of Care meeting. These processes and reviews will continue on an ongoing basis. 4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON will bring the results of the QA audits to the interdisciplinary team meeting 5 days per week, the weekly Standards of Care meeting, the monthly QA&A Committee meeting and to the quarterly QA&A Committee meeting that is attended by the medical director for review and recommendations. The QA audit-282 will be done 5 days a week for 30 days, then weekly for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be**	

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			discontinued by the QA&A Committee when 100% compliance is achieved. This process and review of the 24-hour report and review of the focus charting 5 days per week will continue on an ongoing basis even when documented audits are no longer required by the QA&A Committee. Date of compliance: May 5, 2011. **Addendum to F 282** **a.) *Has the in-service for the Nurses and QMAs been completed?*** **Yes. The inservice was conducted 4-28-2011 and ongoing.** **b.) *What was the content?*** **The content included the facility policy and procedure for physician orders, physician order-monthly recap, change in condition, focus charting, expectations and 5 Rs of medication administration.** **c.) *What process was completed to determine no other residents were affected?*** **During the survey the Director of Nurses checked every treatment to ensure it**	

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			had been done and was dated and initialed by the nurse that completed the treatment. No other residents were identified as having out-dated treatments.	
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to provide for the personal care needs of residents who were dependent for care in activities of daily living for 3 of 5 residents reviewed related to hygiene and grooming in a sample of 9 residents. (Residents B, C, and J) Findings include: 1. During Initial Tour of the facility on 4/4/11 at 11:30 a.m., Resident C was observed seated in his wheel chair in the hallway. The resident was unshaven and had bits of skin and debris around the lips and mouth. The resident was observed in the dining room awaiting lunch service on 4/4/11 at 12:15 p.m. The	F0312	**F312 It is the policy of this facility that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.** **1.What corrective action will be accomplished for those residents found to have been affected by the deficiency?** **Residents that are unable to carry out activities of living independently shall receive grooming and personal and oral hygiene care by facility CNAs as needed. Resident's shall receive shaves as neded or ordered. The facility has a "guardian angel program", by which each department manager is assigned a group of residents to monitor to ensure residents receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.** **2.How will the facility identify other residents having the**	05/05/2011

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	resident remained unshaven and the bits of skin and debris remained about the mouth. When lunch was served, the resident was observed feeding himself with built-up utensils. On 4/5/11 at 10:05 a.m., Resident C was observed in his room in bed with his eyes closed. The front of the resident's undershirt was stained with yellow radiating out from the neck area down the chest. On 4/5/11 at 12:55 p.m., Resident C was observed in his wheel chair in the hallway outside his room. The resident's undershirt was stained with the same yellow stain radiating out from the neck area down the chest. Bits of food debris were observed on the shirt also. Review of the CNA Assignment, received from CNA #10 on 4/4/11 at 12:15 p.m., indicated Resident C required incontinence care, maximum assistance for bathing, was transferred by lift, and heels		**potential to be affected by the same practice and what corrective action will be taken? The Director of Nurses or designee, charge nurse's and department managers shall make frequent rounds and monitor residents regularly to ensure residents are shaven, free from dirty faces, in clothing that is not soiled or stained and receive personal and oral hygiene as needed. 3.What measures will be put into place to ensure this practice does not recur? The Director of Nurse's or designee will conduct random checks on three (3) residents per day on varying shifts 5 days per week for 30 days, then 3 times per week for 30 days to ensure residents that are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene In addition to the random checks done by the Director of Nurses or designee, as part of the facility "guardian angel program" the departments managers shall make frequent rounds and monitor care and services to the residents. If the manager(s) identify a resident that is unable to carry out activities of daily living and is in need of care it shall be**	

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	were floated in bed. Special instructions in the "Instructions" column included, but were not limited to, "...Must be shaved daily...." 2. During observation on the Initial Tour on 4/4/11 at 11:30 a.m., Resident B was observed in bed. During observation in the dining room on 4/4/11 at 12:15 p.m., Resident B was seated in a slightly reclined high-backed wheelchair. The resident's meal had not been served. Crusty, thick yellow debris was observed on the lips and sides of the resident's face and down the chin. Thick strings of yellow substance were clinging to and connected between the resident's slightly parted lips. Before staff began to feed the resident, she was observed using the right hand to rub at the debris on the lips and around the mouth. Review of the CNA Assignment for Resident B indicated two asterisks		**reported to the charge nurse and director of Nurse's immediately. The Director of Nurses will ensure the resident is taken care of at once. Once the resident's needs have been taken care of, the Director of Nurse's will address the identified issue(s) with the involved staff, including re-training as necessary and progressive disciplinary action for continued noncompliance. The DON or designee will document the random checks using QA audit form -312 and bring the results to the interdisciplinary team meting at the next scheduled morning management meeting that is held at least 5 days per week. Department manager "guardian angel program" rounds shall be documented on the "guardian angel program" form and the results shall be reviewed by the interdisciplinary team at the next scheduled morning management meeting that is held at least 5 days per week. In addition, any resident changes will be discussed weekly at the Standards of Care meeting. These processes and reviews will continue on an ongoing basis. 4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA**	

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	next to the resident's name. In the "Bath Instructions" column were two asterisks and "Oral care every shift and prn [as needed]" followed by two asterisks. 3. During observation in the dining room on 4/4/11 at 12:15 p.m., Resident J was seated at the table awaiting lunch. The resident's lips were observed to have a heavy yellow crust of debris. The tongue was visible and had a heavy yellow coating. During interview on 4/5/11 at 2:20 p.m. the concerns related to care of Residents B, C, and J were discussed with the Director of Nursing (DON). The DON nodded. She indicated providing care for Resident J was a challenge. This federal tag relates to Complaints IN00088379 and IN00088699. 3.1-38(a)(3)(C) 3.1-38(a)(3)(D)		**will be put into place? The DON will bring the results of the QA audits to the interdisciplinary team meeting 5 days per week, the weekly Standards of Care meeting, the monthly QA&A Committee meeting and to the quarterly QA&A Committee meeting that is attended by the medical director for review and recommendations. The QA audit-312 will be done 5 days a week for 30 days, then weekly for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be discontinued by the QA&A Committee when 100% compliance is achieved. This process and review of the 24-hour report and review of the focus charting 5 days per week will continue on an ongoing basis even when documented audits are no longer required by the QA&A Committee. Date of compliance: May 5, 2011.** **Addendum to F 312 a.) *What actions were taken for Resident C, Resident B and Resident J?* Resident C- During the survey the Director of Nurses instructed the CNA to change the resident C's clothing and also to shave the resident immediately. Resident B- Once the Director of Nurses**	

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			was made aware that the resident needed oral care she instructed the CNA to provide oral care to the resident immediately. Resident J. - Once the Director of Nurses was made aware that the resident needed oral care she instructed the CNA to provide oral care to the resident immediately. b.) Were other residents assessed for care needs? Yes. All other residents were assessed for care needs and care was provides as needed. The Director of Nurses made sure that all identified residents needing care had their care needs met appropriately by staff. Once that was done, she followed up with staff as indicated in #3 of F312 on the POC. c.) Was staff in-serviced and/or re-education provided? Yes. The facility policy and procedure for oral hygiene and denture care with post test was conducted 4/28/2011 and ongoing. d.) What was the content of the program? Oral hygiene and denture care inservicing included the purpose of oral hygiene/denture care and times during the day when oral hygiene shall be rendered.	

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F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview, and record review, the facility failed to ensure portable oxygen tanks were filled, tested correctly, and functioning to check contents for providing oxygen to residents using the portable tanks. The deficient practice affected 3 of 4 residents whose tanks were observed in a sample of 9 residents. (Residents C, D, and F) Findings include: 1. During Initial Tour of the facility on 4/4/11 at 11:30 a.m., Resident C was observed seated in his wheel chair in the hallway. On the resident's wheel chair was a portable oxygen tank with tubing to a nasal cannula to the resident's	F0328	**F328 It is the policy of this facility to ensure that resident's receive proper treatment and care for special services.** **1.What corrective action will be accomplished for those residents found to have been affected by the deficiency? Both licensed and unlicensed nursing staff has been inserviced on how to check, when to check and when to fill portable oxygen tanks. 2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents with physician orders for oxygen use have the potential to be affected by this practice. As stated previously both licensed and unlicensed nursing staff have been inserviced on how to check, when to check and when to fill portable oxygen tanks. 3.What measures will be put into place to ensure this practice does not recur? The Director of**	05/05/2011

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	nose. During interview at this time, the MDS (Minimum Data Set) Coordinator was asked to check the level of oxygen in the tank. The MDS Coordinator lifted and tilted the tank. The indicator arrow was observed to point to the line between the red zone and the green zone of the indicator knob. The MDS Coordinator indicated the tank was "almost empty," removed the tank from the resident's wheel chair, and sent it for refill. The clinical record for Resident C was reviewed on 4/4/11 at 4:20 p.m. The physician's orders for April 2011 included, but were not limited to, "O2 [oxygen] @ 2L/NC [two liters per minute by nasal cannula] continuous." 2. During observation in the dining room on 4/4/11 at 12:15 p.m., Resident F was seated at the table eating lunch. CNA #7 was asked to check the oxygen in the portable tank on the back of Resident F's wheel chair. CNA #7 lifted and		**Nurse's or designee will conduct random checks on three (3) residents per day on varying shifts 5 days per week for 30 days, then 3 times per week for 30 days to ensure resident that have orders for oxygen have oxygen tanks that have been filled and that staff know when and how to fill oxygen tanks. If the Director of Nurse's or designee find oxygen tanks that are empty or staff do not know when and how to fill oxygen tanks, the Director of Nurse's or designee will immediately take care of the resident's needs. Once the resident's needs have been taken care of, the Director of Nurse's will address the identified issue(s) with the involved staff, including re-training as necessary and progressive disciplinary action for continued noncompliance. The DON or designee reviewing the 24 hour report and focus charting will complete the QA audit form F328 at least 5 days per week and bring the results to the interdisciplinary team meeting at the next scheduled morning management meeting that is held at least 5 days per week. In addition, any resident changes will be discussed weekly at the Standards of Care meeting. These processes**	

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	tilted the tank and indicated the tank was empty and stated, "I'll go fill up the air for you." After CNA #7 left the dining room to fill the tank, the Director of Nursing came into the dining room, and during interview at this time, indicated CNA #7 did not know how to read the oxygen tank properly and that Resident F's portable oxygen tank was actually about one-third full. She indicated the aide was going to fill it now. The clinical record for Resident F was reviewed on 4/4/11 at 4:15 p.m. Physician's orders for April 2011 included, but were not limited to, "O2 @ 2L/NC continuously." 3. During observation in the dining room on 4/4/11 at 12:15 p.m., the DON was asked for the setting and to check the level of oxygen in the portable tank on the back of the wheel chair of Resident D, which was connected to the tubing to the resident's nasal cannula. The DON indicated the tank was set on "three		**and reviews will continue on an ongoing basis. 4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON will bring the results of the QA audits to the interdisciplinary team meeting 5 days per week, the weekly Standards of Care meeting, the monthly QA&A Committee meeting and to the quarterly QA&A Committee meeting that is attended by the medical director for review and recommendations. The QA audit-328 will be done 5 days a week for 30 days, then weekly for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be discontinued by the QA&A Committee when 100% compliance is achieved. This process and review of the 24-hour report and review of the focus charting 5 days per week will continue on an ongoing basis even when documented audits are no longer required by the QA&A Committee. Date of compliance: May 6, 2011.** **Addendum to F 328** **a.)** ***What actions were taken for Resident C, Resident D and Resident F?***	

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	[liters of oxygen per minute]." She lifted and tilted the tank and indicated the tank was "not registering" any contents. She removed the tubing from the tank and indicated the whistling through the tank opening told her there was oxygen in the tank. She indicated she would replace the resident's tank and notify the respiratory company of the problem. She indicated the respiratory company visits once a week. The clinical record for Resident D was reviewed on 4/4/11 at 2:00 p.m. Physician's orders received at the time of admission on 3/19/11 included, but were not limited to, "O2 at 3L/min [minute] via N/C continuously." During observation in Resident D's room on 4/5/11 at 11:00 a.m. with the MDS Coordinator, she looked at the resident's portable oxygen tank on the back of the resident's wheel chair and indicated the resident's portable tank was set at		**Residents C, D and F physician orders for oxygen have been reviewed. CNA assignment sheets and care plans have been reviewed and updated as needed to identify residents that have orders for oxygen therapy, what those orders are and it is listed on the treatment administration record (TAR).** **Every shift the licensed nurse shall check the liter flow, assess resident's respirations and blood oxygen saturation and document it on the treatment administration sheet (TAR).** **In addition to the above every resident receiving oxygen therapy shall have their portable oxygen tank checked prior to each use. If its contents are ¼ full or less the tank shall be filled prior to being used.** **b.)** ***Was re-education and/or in-service provided to staff?*** **Yes. Inservicing began on April 13, 2011.**	

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	1.5 liters per minute. She indicated a physician's order had been received to titrate the resident's oxygen down, with the goal of the resident's returning home without daytime oxygen therapy. The MDS Coordinator indicated the CNAs were responsible for switching residents from the concentrator to the portable tank when needed. The facility's policies related to portable oxygen therapy tanks were provided by the DON on 4/5/11 at 11:30 a.m. Review of "Filling of Liquid Portables" indicated, "...11. Check the liquid oxygen contents indicator to ensure the portable is filled to the green full area...." Review of "Companion Portable Units" indicated, "Contents Indicator: located on top of the Portable....The pointer indicates approximately how much oxygen remains in the unit...." This federal tag relates to Complaint IN00088379.		**c.) *What was the content of the program?*** **Nursing staff were in-serviced on accurately reading the gauges on the oxygen tanks, filling oxygen tanks, including when and how to fill portable tanks. Return demonstration performed by nursing staff to assure that they learned the information and are able to perform as expected.** **d.) Were all residents with the need and/or the physician's order for oxygen assessed?** **Yes. All residents who have current orders for oxygen are assessed every shift.** **The licensed nurse checks the liter flow, assesses the resident's respirations and blood oxygen saturation and documents it on the treatment administration sheet (TAR) each shift.**	

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview, the facility failed to ensure staff used handwashing and gloving	F0441	**F441 It is the policy of this facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help**	05/05/2011

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	techniques described in facility policy and procedure when providing incontinence care to 3 of 3 residents observed for incontinence care in a sample of 9 residents. (Residents B, C, and H) Findings include: 1. During observation of care on 4/4/11 at 1:30 p.m., CNA #10 and CNA #2 were observed providing incontinent care to Resident C. CNA #2 wore gloves to empty the trash. She removed her gloves, and without washing her hands or using hand sanitizer, she donned clean gloves. CNA #10 was also wearing gloves. The CNAs assisted the resident to stand using the stand-up lift, cleansed the perineal area and soft stool from the anal area. Without removing her gloves and washing her hands or using hand sanitizer, CNA #2 rummaged in the drawer of Resident C's night stand and indicated to CNA #10 to remind her to get barrier cream for the resident. The resident was		**prevent the development and transmission of disease and infection including the appropriate use of gloves and hand washing. 1.What corrective action will be accomplished for those residents found to have been affected by the deficiency? The Director of Nurse's will inservice nursing staff on infection control including, incontinence care, proper glove use, and the procedures for hand washing and for use of alcohol-based hand rub. 2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to be affected by this practice. As stated above, the Director of Nurse's will inservice nursing staff on the facility policy for infection control including, incontinence care and hand washing/alcohol-based hand rub. If any staff is observed not to follow the facility policies and procedures in regards to wearing and removal of gloves with appropriate use of handwashing or alcohol based hand rub, the DON will stop the staff person at that time, have him/her remove gloves and wash hands or use the alcohol based hand rub before**	

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	transferred to the bed and the bed covers arranged. Both CNAs removed their gloves. CNA #2 left the resident's room without washing her hands or using hand sanitizer. CNA #10 remained to clean the resident's wheel chair. 2. During observation of care on 4/4/11 at 3:30 p.m., CNA #3 and CNA #8 were observed providing incontinent care to Resident B. Both CNAs were wearing gloves. CNA # 8 assisted to remove the brief, and CNA #3 cleansed the resident's perineal area and cleansed stool from the anal area. Without changing gloves, CNA #3 obtained a tube of barrier cream and applied the cream to the resident's cleansed anal area. CNA #3 then removed her gloves, washed her hands, and donned clean gloves. As the two CNAs were rolling the resident from side to side, CNA #10 rolled and removed a draw sheet containing smears of stool and placed sheet in a bag with soiled linens. CNA #10 did not remove		**returning to resident care. Once the resident is taken care of, the DON will inservice the staff involve on the facility policy and procedure for appropriate glove use and handwashing. She will also render progressive discipline for continued noncompliance. 3.What measures will be put into place to ensure this practice does not recur? The Director of Nurses or designee will perform random incontinence observations, including hand-washing after the removal of gloves on two (2) residents 5 day per week for 30 days, then 3 times per week for 30 days to ensure incontinence care is performed in a safe and sanitary manner that prevents the development and transmission of infection and disease. If any staff is observed not to follow the facility policies and procedures in regards to wearing and removal of gloves with appropriate use of handwashing or alcohol based hand rub, the DON will stop the staff person at that time, have him/her remove gloves and wash hands or use the alcohol based hand rub before returning to resident care. Once the resident is taken care of, the DON will inservice the staff involve on the facility**	

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	her gloves and wash her hands or use hand sanitizer. The CNAs proceeded to transfer the resident from bed to chair using the Hoyer lift. After the resident was in the lift, CNA #8 removed her gloves and washed her hands. CNA #3 obtained a wipe and cleansed matter from the right eye of Resident B, and without changing gloves and washing her hands or using hand sanitizer, CNA #3 obtained hair care supplies from the drawer in the resident's bedside table drawer, brushed the resident's hair, and placed a barrette in the hair. 3. During observation on 4/5/11 at 1:30 p.m., CNA #5 and CNA #14 were observed transferring and providing incontinent care for Resident H. The CNAs washed hands and donned gloves. The resident was transferred from wheel chair to bed, and her wet brief was removed. Pericare was provided by CNA #14. CNA #14 then removed her gloves, and without washing		**policy and procedure for appropriate glove use and handwashing. She will also render progressive discipline for continued noncompliance. The DON or designee will complete the QA audit form F441 at least 5 days per week and bring the results to the interdisciplinary team meting at the next scheduled morning management meeting that is held at least 5 days per week. In addition, any resident changes will be discussed weekly at the Standards of Care meeting. These processes and reviews will continue on an ongoing basis. 4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON will bring the results of the QA audits to the interdisciplinary team meeting 5 days per week, the weekly Standards of Care meeting, the monthly QA&A Committee meeting and to the quarterly QA&A Committee meeting that is attended by the medical director for review and recommendations. The QA audit-441 will be done 5 days a week for 30 days, then weekly for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be**	

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	hands or using hand sanitizer, applied clean gloves. She applied barrier cream to the resident's perineal and anal area. CNA #14 then removed her gloves, and without washing hands or using hand sanitizer, applied clean gloves. CNA #14 and CNA #5 then assisted Resident H to a comfortable position, removed their gloves, and washed their hands. The facility's policy and procedure related to handwashing and glove use was provided by the Director of Nursing on 4/5/11 at 2:20 p.m. The policy was entitled "Handwashing/Alcohol-Based Hand Rub" and dated as revised 7/10. Guidelines indicated, "...in the absence of a true emergency, personnel should always [underlined] wash their hands (even when gloves are worn): As promptly and thoroughly as possible after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them, whether or		**discontinued by the QA&A Committee when 100% compliance is achieved. This process and review of the 24-hour report and review of the focus charting 5 days per week will continue on an ongoing basis even when documented audits are no longer required by the QA&A Committee. Date of compliance: May 5, 2011.** **Addendum to F 441** **a.)** ***What actions were taken for Resident B, Resident C and Resident H?*** **The DON or designee has observed pericare and personal care being rendered to Residents B, C, and H by CNA staff at least weekly as part of the random incontinence care observations that were described in #3 of the plan of correction previously submitted. She or a designee will observe this care on varied shifts to ensure that each resident has received appropriate treatment, including glove use and handwashing. Any identified issues will be dealt with as described in #3 of the POC.**	

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	not gloves are worn; after gloves are removed; after situations during which microbial contamination of hands is likely to occur, especially...body fluids...or items contaminated with these substances; when otherwise indicated to avoid transfer of microorganisms to other residents and environments; ...when indicated between tasks and procedures on the same resident to prevent cross-contamination of different body sites; ...Before and after each resident contact; ...After touching a resident or handling his/her belongings...." 3.1-18(l)			